STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/17/17 through 10/19/17. Four complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 131 at the time of the survey. The survey sample consisted of 27 resident reviews; 22 current residents (Residents #1 through #22) and 5 closed record reviews (Residents #23 through #27).	F 000		
F 203 SS=D	NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE CFR(s): 483.15(c)(3)-(6)(8) (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 203		12/3/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/08/2017

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F 203	Continued From page 1	F 203		

paragraph (b)(5) of this section.

(c) (4) Timing of the notice.

(i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when-

(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(c) (5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;

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F 203	Continued From page 2 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the	F 203		

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F 203	Continued From page 3 recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review and during the course of a complaint investigation the facility staff failed to notify the resident or Resident Representatives of a discharge while hospitalized for 2 of 27 residents in the survey sample, Resident #26 and 27. The findings included: 1. A report was received in the State Survey Agency from the representative of the Office of the State Long-Term Ombudsman on 5/18/17. The report stated that the facility had refused to readmit Resident #26 who was hospitalized at the time and awaiting discharge back to the facility. The report stated a discharge notice was not provided to Resident #26 from the facility prior to discharge to the hospital or during the resident's hospital stay. Resident #26 was admitted to the facility on 10/31/16 following a hospitalization for an above the knee amputation of the left leg on 10/26/16.	F 203	F-203 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility did not provide a 30 day notice to residents #26 and #27. How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. Notice will be given to the resident and the resident□s representative (s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility will	

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F 203	Continued From page 4 According to the facility face sheet the resident was his own responsible party. The current MDS (Minimum Data Set) prior to the resident's discharge on 5/9/17 to the hospital for a planned surgical procedure was a quarterly with an assessment reference date of 5/4/17 which coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident was coded as having had exhibited physical behavior towards others 1 to 3 days during the assessment period (5/3/17-5/9/17). Under Section J 1300. Current Tobacco Use was blank and not checked for Yes or No. The MDS discharge assessment dated 5/9/17 coded the resident as discharging to a hospital with return anticipated status. The resident was sent to the hospital on 5/9/17 for a scheduled surgical procedure involving the right foot. The Ombudsman Complaint description titled Discharge/eviction-planning, notice, procedure report was initiated on 5/15/17. The Journal Entries stated that on 5/15/17 a call was received from the hospital case management supervisor. She reported that the facility is refusing to readmit the resident. The Ombudsman contacted the facility and spoke with the CEO/Administrator. The Administrator stated that they could not meet the resident's needs. The Ombudsman documented, "When I asked the facility administrator why he was not accepting the resident back he stated that the resident tends to smoke in the building and has had some	F 203	sent a copy of the notice to the Office of the State long-Term Care Ombudsman. Facility will document the reasons for the transfer or discharge in the resident□s medical record. Notice of transfer or discharge will be made at least 30 days before the resident is transferred or discharged. Notice must be made as soon as practicable before transfer or discharge when- Safety of individuals in the facility would be endangered. The health of individuals in the facility would be endangered. Resident□s health improves sufficiently to allow more immediate transfer or discharge. A resident has not resided in the facility for 30 days. The written notice must include- The reason for transfer or discharge The effective date of transfer or discharge The location to which the resident is transferred or discharged. A statement of the residents appeal rights, including name, address (mailing and email) and the telephone number of the entity which receives such requests; and information on how to obtain an appeal form and submitting the appeal hearing request. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. A Policy and Procedure on discharging a hospitalized resident will be written and education will be provided to Social Services Director.	

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F 203	Continued From page 5 behavioral issues. I recommended that the facility take the resident back and issue a 30 day discharge notice but the facility refused to do this". The entry dated 5/16/17 stated a follow up call to the hospital was made. They reported that they had found alternate placement for the resident in another long term care facility. The entry dated 5/18/17 stated a discharge from the nursing facility was not delivered to the resident. On 10/18/17 at 4:20 p.m., an interview was conducted with the CEO/Administrator. The Administrator was asked if he was aware that a hospitalized resident requires a discharge notice, he stated, "Yes, (name of Ombudsman) told me this...I was not aware of it at that time...I probably did not get the memo". The Administrator was asked if the facility had a written policy on discharging a hospitalized resident, he stated, "No". The Administrator was asked why Resident #26 was not given a discharge notice. He stated, "We could have given a discharge notice...we didn't". When asked why the facility did not proceed with a discharge notice when the resident was found smoking in his room on several occasions prior to the hospitalization he stated, "To where...he would have appealed.. that's 45 days and no one would have taken him". The Administrator was asked if the facility had tried to find alternate placement for the resident and he stated, "Yes, we tried". The Administrator was asked to provide documentation indicating that the facility had attempted to find an alternate place, he stated this would be found in the Social Service notes. Review of the Social Services notes did not provide any documentation that an attempt to find alternate placement was made. On 10/19/17 at 12:00 p.m., the Ombudsman was	F 203	Indicate how the facility plans to monitor its performance to make to ensure that solutions are sustained. The Facility CEO/Administrator will review the conditions that a resident can be Transferred or discharged. Safety of individuals in the facility would be endangered. The health of individuals in the facility would be endangered. Resident□s health improves sufficiently to allow more immediate transfer or discharge. Resident has not resided in the facility for 30 days There is failure, after reasonable and appropriate notice, to pay (or have paid under Medicaid or Medicare) for a stay in the facility. Completion Date: 12/3/17	

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interviewed via the telephone. The complaint was reviewed. The Administrator stated that the reason for refusing to readmit Resident #26 was because of the resident's smoking and behavior. The Ombudsman stated he had discussed with the Administrator that the facility was supposed to deliver a 30 day notice of discharge for hospitalized residents. He stated the facility did not send a 30 day notice of discharge to the resident nor did the facility send a copy of a discharge notice to the Ombudsman office.

On 10/19/17 at 3:30 p.m., the above findings was shared during the pre-exit meeting. The Administrator was asked under what condition was the resident discharged based on the six conditions. He indicated the fourth condition; the health of individuals in the facility would otherwise be endangered. When asked if the facility had given the resident a discharge notice, he stated "No".

A request for the facility's policy for Transfer/Discharge of residents was made. The facility provided a copy of several pages from the Beacon Shores Health & Rehab Center Admission/Resident Handbook that read, in part:
The facility may transfer or discharge you under any of the following conditions:
4. The health of individuals in the Facility would otherwise be endangered.
The facility will provide notice to you and your Responsible Party and, if known, a designated family member of your transfer or discharge and the reason for it at least thirty (30) days before you are transferred or discharged. Where your health and safety or the health and safety of other individual in the Facility may be endangered, however, or where other good cause or legal

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reasons exist, notice may be given as soon as practicable before your transfer or discharge.

2. A report was received in the State Survey Agency from the representative of the Office of the State Long-Term Ombudsman on 5/18/17. The report stated that the facility had refused to readmit Resident #27 who was hospitalized at the time and awaiting discharge back to the facility. The report stated a discharge notice was not provided to Resident #27/ Resident Representative from the facility prior to discharge to the hospital or during the resident's hospital stay.

Resident #27 was admitted to the facility on 12/30/15 with diagnoses to include, but not limited to dementia with behavioral disturbances, adjustment disorder with anxiety, delusional disorder and depression. According to the facility face sheet the resident's sister was his Responsible Representative.

The current MDS (Minimum Data Set) prior to the resident's discharge on 4/28/17 to the hospital for a change in condition was a a quarterly with an assessment reference date of 3/30/17 coded the resident as scoring a 2 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident had severely impaired cognition. The resident was coded as having had exhibited physical behavior towards others 1 to 3 days during the assessment period (4/22/17-4/28/17).

The MDS discharge assessment dated 4/28/17 coded the resident as discharging to a hospital with return anticipated status.

The resident was sent to the hospital on 4/28/17

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for a change in condition; described as non-ambulatory and non-verbal in the nurses notes.

The Ombudsman Complaint description titled Discharge/eviction-planning, notice, procedure report was initiated on 5/15/17. The Journal Entries stated that on 5/15/17 a call was received from the hospital case management supervisor. She reported that the facility is refusing to readmit the resident citing they were unable to meet the needs of the resident. The Ombudsman documented the following: "The resident was admitted with severe cognitive impairment due to mixed dementia. The resident has a psych history and was being followed by the psychiatric nurse and was on the facility secure unit. The chart had some documentation on the resident demonstrating aggressive behavior with some times refusing care. When I called the nursing {sic} to attempt to get them to readmit the resident and give him a 30 day discharge, they refused. I attempted to get the administrator to call the hospital to see if they could work out an agreement on readmitting the resident, I was told that they (the administrator) might not call them." The entry dated 5/16/17 stated a follow up call to the hospital was made. They reported that they had found alternate placement for the resident in another long term care facility. The entry dated 5/18/17 stated a discharge from the nursing facility was not sent to the resident.

On 10/18/17 at 4:20 p.m., an interview was conducted with the CEO/Administrator. The Administrator was asked if he was aware that a hospitalized resident requires a discharge notice, he stated, "Yes, (name of Ombudsman) told me this...I was not aware of it at that time...I probably

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did not get the memo". The Administrator was asked if the facility had a written policy on discharging a hospitalized resident, he stated, "No". The Administrator was asked why Resident #27 was not given a discharge notice. He stated, "We could have given a discharge notice...we didn't".

On 10/19/17 at 12:00 p.m., the Ombudsman was interviewed via the telephone. The complaint was reviewed. The Administrator stated that the reason for refusing to readmit Resident #27 was because of the resident's behavior. The Ombudsman stated he had discussed with the Administrator that the facility was supposed to deliver a 30 day notice of discharge for hospitalized residents. He stated the facility did not send a 30 day notice of discharge to the resident nor did the facility send a copy of a discharge notice to the Ombudsman office.

On 10/19/17 at 3:30 p.m., the above findings was shared during the pre-exit meeting. The Administrator was asked under what condition was the resident discharged based on the six conditions. He indicated the fourth condition; the health of individuals in the facility would otherwise be endangered. When asked if the facility had given the resident a discharge notice, he stated "No".

A request for the facility's policy for Transfer/Discharge of residents was made. The facility provided a copy of several pages from the Beacon Shores Health & Rehab Center Admission/Resident Handbook that read, in part:
The facility may transfer or discharge you under any of the following conditions:
4. The health of individuals in the Facility would

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F 203	Continued From page 10 otherwise be endangered. The facility will provide notice to you and your Responsible Party and, if known, a designated family member of your transfer or discharge and the reason for it at least thirty (30) days before you are transferred or discharged. Where your health and safety or the health and safety of other individual in the Facility may be endangered, however, or where other good cause or legal reasons exist, notice may be given as soon as practicable before your transfer or discharge.	F 203		
F 206 SS=D	COMPLAINT DEFICIENCY POLICY TO PERMIT READMISSION BEYOND BED-HOLD CFR(s): 483.15(e)(1)(2) (e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.	F 206		12/3/17

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F 206	Continued From page 11 (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. (e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview and during the course of a complaint investigation the facility staff failed to establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. A report was received in the State Survey Agency from the representative of the Office of the State Long-Term Ombudsman on 5/18/17. The report stated that the facility had refused to readmit Resident #26 and Resident #27 who were hospitalized at the time and awaiting discharge back to the facility. The report stated a discharge notice was not provided to both residents from the facility prior to discharge to the hospital or during the resident's hospital stay. The findings included:	F 206	F-206 (1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Facility did not have written policy for discharging a hospitalized resident that effected resident #26 & #27 (2) How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. (3) What measure will be put in place or systemic changes made to ensure that the deficient practice will not	

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F 206	Continued From page 12 Resident #26 was admitted to the facility on 10/31/16 following a hospitalization for an above the knee amputation of the left leg on 10/26/16. The current MDS (Minimum Data Set) prior to the residents discharge on 5/9/17 to the hospital for a planned surgical procedure was a quarterly with an assessment reference date of 5/4/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident was coded as having had exhibited physical behavior towards others 1 to 3 days during the assessment period (5/3/17-5/9/17). Under Section J 1300. Current Tobacco Use was blank and not checked for Yes or No. The MDS discharge assessment dated 5/9/17 coded the resident as discharging to a hospital with return anticipated status. The resident was sent to the hospital on 5/9/17 for a scheduled surgical procedure involving the right foot. The Ombudsman Complaint description titled Discharge/eviction-planning, notice, procedure report was initiated on 5/15/17. The Journal Entries stated that on 5/15/17 a call was received from the hospital case management supervisor. She reported that the facility is refusing to readmit the resident. The Ombudsman contacted the facility and spoke with the CEO/Administrator. The Administrator stated that they could not meet the resident's needs. The Ombudsman documented, "When I asked the facility administrator why he was not accepting the resident back he stated that the resident tends to smoke in the building and has had some	F 206	recur. See F-Tag 203 (4) Indicate how the facility plans to monitor its performance to make to ensure that solutions are sustained. The Facility CEO/Administrator will review the conditions that a resident can be Transferred or discharged. Safety of individuals in the facility would be endangered. The health of individuals in the facility would be endangered. Resident□s health improves sufficiently to allow more immediate transfer or discharge. Resident has not resided in the facility for 30 days There is failure, after reasonable and appropriate notice, to pay (or have paid under Medicaid or Medicare) for a stay in the facility (5)Completion Date: 12/3/17	

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	495150	A. BUILDING _____ B. WING _____	C 10/19/2017

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behavioral issues. I recommended that the facility take the resident back and issue a 30 day discharge notice but the facility refused to do this". The entry dated 5/16/17 stated a follow up call to the hospital was made. They reported that they had found alternate placement for the resident in another long term care facility. The entry dated 5/18/17 stated a discharge from the nursing facility was not delivered to the resident.

On 10/18/17 at 4:20 p.m., an interview was conducted with the CEO/Administrator. The Administrator was asked if he was aware that a hospitalized resident requires a discharge notice, he stated, "Yes, (name of Ombudsman) told me this...I was not aware of it at that time...I probably did not get the memo". The Administrator was asked if the facility had a written policy on discharging a hospitalized resident, he stated, "No".

On 10/19/17 at 12:00 p.m., the Ombudsman was interviewed via the telephone. The complaint was reviewed. The Administrator stated that the reason for refusing to readmit Resident #26 was because of the resident's smoking and behavior. The Ombudsman stated he had discussed with the Administrator that the facility was supposed to deliver a 30 day notice of discharge for hospitalized residents. He stated the facility did not send a 30 day notice of discharge to the resident nor did the facility send a copy of a discharge notice to the Ombudsman office.

On 10/19/17 at 3:30 p.m., the above findings of the facility's failure to establish and follow a written policy on permitting residents to return to the facility after they are hospitalized was shared during the pre-exit meeting.

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2. Resident #27 was admitted to the facility on 12/30/15 with diagnoses to include, but not limited to dementia with behavioral disturbances, adjustment disorder with anxiety, delusional disorder and depression.

The current MDS (Minimum Data Set) prior to the resident's discharge on 4/28/17 to the hospital for a change in condition was a a quarterly with an assessment reference date of 3/30/17 coded the resident as scoring a 2 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident had severely impaired cognition. The resident was coded as having had exhibited physical behavior towards others 1 to 3 days during the assessment period (4/22/17-4/28/17).

The MDS discharge assessment dated 4/28/17 coded the resident as discharging to a hospital with return anticipated status.

The Ombudsman Complaint description titled Discharge/eviction-planning, notice, procedure report was initiated on 5/15/17. The Journal Entries stated that on 5/15/17 a call was received from the hospital case management supervisor. She reported that the facility is refusing to readmit the resident citing they were unable to meet the needs of the resident. The Ombudsman documented the following: "The resident was admitted with severe cognitive impairment due to mixed dementia. The resident has a psych history and was being followed by the psychiatric nurse and was on the facility secure unit. The chart had some documentation on the resident demonstrating aggressive behavior with some times refusing care. When I called the nursing {sic} to attempt to get them to readmit the

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resident and give him a 30 day discharge, the refused. I attempted to get the administrator to call the hospital to see if they could work out an agreement on readmitting the resident, I was told that they (the administrator) might not call them." The entry dated 5/16/17 stated a follow up call to the hospital was made. They reported that they had found alternate placement for the resident in another long term care facility. The entry dated 5/18/17 stated a discharge from the nursing facility was not sent to the resident.

On 10/18/17 at 4:20 p.m., an interview was conducted with the CEO/Administrator. The Administrator was asked if he was aware that a hospitalized resident requires a discharge notice, he stated, "Yes, (name of Ombudsman) told me this...I was not aware of it at that time...I probably did not get the memo". The Administrator was asked if the facility had a written policy on discharging a hospitalized resident, he stated, "No".

On 10/19/17 at 12:00 p.m., the Ombudsman was interviewed via the telephone. The complaint was reviewed. The Administrator stated that the reason for refusing to readmit Resident #27 was because of the resident's behavior. The Ombudsman stated he had discussed with the Administrator that the facility was supposed to deliver a 30 day notice of discharge for hospitalized residents. He stated the facility did not send a 30 day notice of discharge to the resident nor did the facility send a copy of a discharge notice to the Ombudsman office.

On 10/19/17 at 3:30 p.m., the above findings of the facility's failure to establish and follow a written policy on permitting residents to return to

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F 206	Continued From page 16 the facility after they are hospitalized was shared during the pre-exit meeting.	F 206		
F 274 SS=D	COMPLAINT DEFICIENCY COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) manual the facility staff failed to complete a significant change assessment for 1 of 27 residents (Residents #10), in the survey sample. The facility staff failed to complete a significant change Minimum Data Set (MDS) assessment for Resident #10 after staff recognized the resident had experienced a decline in 2 or more areas. The findings included;	F 274	F-274 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Significant Change in Status was opened and submitted, with an ARD of 10/19/17 for resident #10 after determining that the resident had a decline in functional status. How the facility will identify other residents having the potential to be affected by the	12/3/17

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F 274	Continued From page 17 Resident #10 was originally admitted to the facility 6/26/10, and was readmitted to the facility 11/14/14 after an acute hospitalization. The current diagnoses included a stroke, psychosis, an anxiety disorder, depression, Crohn's disease, a seizure disorder, pain, hepatitis-C, and coronary artery disease. Resident #10 had a quarterly MDS assessment completed with an ARD of 8/15/17. It coded the resident as completing the Brief Interview for Mental Status and scoring 14 out of a possible 15. This indicated Resident #10's cognitive abilities for daily decision making was intact. This MDS assessment also coded the resident in section "G" Functional Status, as requiring extensive assistance of 1 person with personal hygiene and toileting as well as no in-room walking during the observation period. In section "H" Bladder and Bowel, the resident was coded as frequently incontinent of bowels and bladder. Resident #10's annual MDS assessment with an assessment reference date (ARD) of 5/23/17 coded the resident as completing the Brief Interview for Mental Status with a score of 15 out of a possible 15. This indicated Resident #10's cognitive abilities for daily decision making was intact. This MDS assessment also coded the resident in section "G" Functional Status, as requiring limited assistance of 1 person with personal hygiene, toileting and in-room walking. In section "H" Bladder and Bowel, the resident was coded as continent of bowels and frequently incontinent bladder.	F 274	same deficient practice. 1. All resident have the potential to be affected. What measures will be put in place or systemic change made to ensure that the deficient practice will not recur. 1. Review of any changes on resident□s condition will be discussed in the morning meeting and At Risk Meetings to determine a Significant Change in Status 2. Monitoring Tool will be in place for determining Significant Change 3. Weekly x 1 month 4. Weekly x 2 weeks 5. Randomly x 3 months 6. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed. (4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. 1. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed (5) Completion Date: 12/3/2017	

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On 10/19/17 at approximately 3:20 p.m., an interview was conducted with the MDS Coordinator. The MDS Coordinator stated the resident had experienced multiple falls without injury which was likely the reason for the decline in physical functioning. The MDS Coordinator further stated after comparing the two most recent MDS assessments a significant change MDS assessment should have been completed and it would be scheduled.

On 10/19/17 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated a significant change assessment would be completed to capture the resident's current status.

The MDS 3.0 RAI manual states a significant change is a decline or improvement in the resident's status: Resident #10 experienced improvements in two or more of the following:
- Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
- Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
- Resident's decision making changes for the better;
- Resident's incontinence pattern changes for the better;
- Overall improvement of resident's condition.

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F 274	Continued From page 19 RAI user's manual, Chapter 2 page 2-26, October 2016)	F 274		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		12/3/17

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(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

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F 280	Continued From page 21 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review the facility staff failed to update the Care Plan to include noncompliance for 1 Resident (Resident #2) of 27 Residents in the survey sample. The findings included: Resident #2 was admitted to the facility on 8/9/10 with a readmission on 11/7/16. Diagnoses for Resident #2 included but are not limited to heart failure and history of falls. Resident #2's Annual Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 5/23/17 coded Resident #2 with a score of 15 of 15 on a BIMS (Brief Interview for Mental Status) indicating no cognitive impairment. In addition, the Annual MDS coded Resident #2 as requiring extensive assistance with two staff person assistance for transfers. Resident #2's three Resident Incident Reports, documented falls on the following: 5/26/17 Incident type: Fall/no head injury Narrative: Resident found on the floor stated she was trying to go to bed and lost her balance. Skin tear noted to left knee. Non-Witnessed Fall	F 280	F-280 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident #2 care plan was revised on 10/19/17- resident non-compliant with plan of care to call for assistance when transferring How the facility will identify other residents having the potential to be affected by the same deficient practice. 1. All resident have the potential to be affected. What measures will be put in place or systemic change made to ensure that the deficient practice will not recur. 1. Interview with Unit Managers to find which residents are non-compliant 2. 100% audit of non-compliant residents will be completed by 11/10/17 3. Non-compliance behavior will be added to Care Plan 4. Monitoring tool will be in place for Care Plan and updates 5. Weekly x 1 month 6. Weekly x 2 weeks	

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F 280	Continued From page 22 Conditions that may have impacted this fall: Resident non-compliance with plan of care 7/20/17 Incident type: Fall/no head injury Narrative: Resident was found in room sitting on her bottom, she stated she was attempting to transfer into wheelchair when she lost her balance and fell. Non-Witnessed Fall Conditions that may have impacted this fall: Resident non-compliance with plan of care 10/9/17 Incident type: Fall with head injury Narrative: Resident was observed on floor in hallway off unit by a CNA (Certified Nursing Assistant). Resident was noted to be bleeding from her head. Resident states her slipper got stuck under the wheel of her chair while self-propelling down the ramp back to her unit and she fell from her chair onto the floor. Left head laceration, left face hematoma with moderate swelling. Immediate Actions Taken: First aid provided, EMS (Emergency Medical Services) contacted for Emergency transport. Non-Witnessed Fall Conditions that may have impacted this fall: Resident non-compliance with plan of care Resident #2's active Care Plan was reviewed and observed to not include: non-compliance with the plan of care. Resident #2's care plan was last updated on 8/30/17 and 11/17/17. Resident #2's Care Plan did include the following: 7/20/17 Fall protocol implemented; re-educate to call for assist; sustained skin tear on Left shin; treatment as ordered; every 15 minute checks for 72 hours; MD (Medical Doctor) and RP (Responsible Party) notified.	F 280	7. Randomly x 3 months 8. Performance Improvement Plan and monitoring tool will be in reviewed in the monthly Quality Assurance and Performance Improvement ongoing for further recommendations and/or suggestions and follow-up as needed. (4) How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. 1. The Director of Nursing will present findings of the monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed (5) Completion Date: 12/3/2017	

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On 10/17/17 at approximately 4:44 p.m., Resident #2 was observed taking her medications. Resident #2 was sitting in her wheel chair and observed to be well groomed. Resident #2 was observed to have bruising on the left side of her face and left arm.

On 10/18/17 at approximately 2:40 p.m., Resident #2 was observed sitting in her wheel chair in day room. She was well groomed, and had bruising on left side of her face and on her left arm.

On 10/19/17 at approximately 3:30 p.m., Resident #2 was observed sitting in her wheel chair in her room. Resident #2 became tearful when talking about her Mother and son not visiting.

On 10/19/17 at approximately 1:35 p.m. the Licensed Practical Nurse (LPN) #1 on Resident #2's unit was asked what was the specific aspect of the Plan of Care that Resident #2 was non-compliant with. LPN #1 stated: "Refusing to wait for help."

On 10/19/17 at approximately 3:30 p.m., Resident #2 was asked if she could state why she felt she had frequent falls. Resident #2 stated: "The staff take so long to come to help that I get up and go to the bathroom as I am not going to wet my panties." When asked how long it takes staff to respond, she stated anywhere from 15 minutes to 1 hour."

During the three days of survey (10/17/17-10/19/17), surveyors did not observe Residents waiting more that 15 minutes to receive assistance. In addition, Residents from the Group Interview did not complain that they

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F 280	Continued From page 24 had long waits for nursing to assist them. The Director of Nursing was asked on 10/19/17 at approximately 2:00 p.m. if she saw the problem of non-compliance to the plan of care included on the Care Plan. The Director of Nursing stated, "No." The Facility Policy and Procedure titled, "Care Planning - Interdisciplinary Team" documented the following: Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The facility administration was informed of the findings during a briefing on 10/19/17 at approximately 3:35 p.m. The facility did not present any further information about the findings.	F 280		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited	F 323		12/3/17

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	495150	A. BUILDING _____ B. WING _____	C 10/19/2017

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BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

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F 323	Continued From page 25 to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and clinical record review the facility staff failed to ensure interventions to prevent injuries from falls were in place according to the resident's identified needs and comprehensive person-centered care plan for 1 of 27 residents in the survey sample, Resident #1. Resident #1 was identified as having a history of falls. The comprehensive person-centered care plan included the use of fall mats to be placed on the floor on both sides of the bed to reduce injury. Only one fall mat was observed in the room and in use when the resident was in bed. The findings included: Resident #1 was admitted to the facility on 2/28/11 with a readmission date of 9/12/14 with diagnoses to include, but not limited to: dementia with behavioral disturbances, osteoporosis (softening of bone-seen most often in elderly) and history of a stroke and falls. The current MDS (Minimum Data Set) with a assessment reference date of 7/11/17 assessed	F 323	F-323 (1)How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident #1 second fall mat was placed in the room on 10/18/17. (2)How the facility will identify other residents having the potential to be affected by the same deficient practice. 1. All residents have the potential to be affected by the deficient practice 2. A 100% audit of all residents with safety devices (ex: alarms and fall mats) will be completed by 11-10-17, and monitoring of safety devices for placement and functioning will be checked each shift by licensed nurses. (3)What measures will be put in place or systemic change made to ensure that the deficient practice will not recur. 1. All licensed nurses will be in-serviced on Fall Prevention Protocol ensuring all residents with safety devices are functioning and in place (ex: alarms and	

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F 323	Continued From page 26 the resident as having long and short term memory deficits with severely impaired daily decision making skills. The resident required extensive assistance of two for bed mobility and transfers. The comprehensive person-centered care plan dated 10/28/16 identified the resident had potential for falls due to a history of falls, diagnosis of osteoporosis, impaired and poor safety awareness, as evidenced from psychotropic medications, resident has a history of sitting self on the floor. The goal was that the risk for falls will be managed through nursing interventions over the next 90 days, last reviewed 10/13/17. One of the interventions listed to achieve and maintain the goal was floor mats at bedtime, while in bed. On 10/17/17 at 2:45 p.m. and 4:00 p.m., Resident #1 was observed sitting up in a wheelchair in the resident's room. One fall mat was observed against the wall. On 10/18/17 at 9:45 a.m., 1:00 p.m., and 3:00 p.m., the resident was observed in bed. One fall mat was observed on the floor on the left side of the bed. On 10/18/17 at 3:30 p.m., the day shift nurse assigned to care for Resident #1 was interviewed (Licensed Practical Nurse #1). She was asked what safety interventions were in place for the resident. She stated, "low bed, fall mats on both sides, self release belt...". The observation of the use of only one fall mat while the resident was asleep in bed all day shift today was shared. Following this interview the nurse was asked to go into the resident's room and observe for two	F 323	fall mats) by 11-10-17. (4)How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. 1. The Unit Managers will formalize a list of residents who have safety devices (ex: alarms and fall mats). 2. The on-coming and off going licensed nurse will round during shift change and use monitoring to check and sign that safety device is in place and functioning (ex: alarms and fall mats). 3. The Unit Managers will conduct periodic compliance rounds in addition to shift change monitoring by licensed nurse. 4. Results of audits and monitoring will be introduced in the monthly Quality Assurance Performance Improvement committee for further recommendations and/or follow up as needed. (5) Completion date: 12/3/2017	

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F 323	Continued From page 27 fall mats. Upon entering the room, the resident was in bed asleep. There was only one fall mat on the floor on the left side of the bed. The nurse was asked if the resident required two fall mats while in bed, she stated, "Yes". On 10/18/17 at 3:45 p.m., the unit manager was interviewed. The above observation was shared. She stated the resident was supposed to have two floor mats while in the bed. When asked why is the resident supposed to have two fall mats, she stated," It's important because she is a fall risk". The above findings were shared during the pre-exit meeting conducted on 10/19/17 at 3:35 p.m., with the CEO, the Director of Nursing and Corporate nurse in attendance.	F 323		
F 465 SS=F	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on general observations, resident and staff interviews, and facility documentation, the facility staff failed to provide a sanitary and	F 465	F-465 How the corrective action(s) will be	12/3/17

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F 465	Continued From page 28 comfortable environment for the residents on 5 out of 5 units. The finding included: On 10/17/17 at 4:30 p.m., the hydration cart, in the patio area where residents were congregating and some smoking, was visibly soiled with accumulated black substance. The cart remained in the same condition until brought to the attention of the Director of Environmental Services on 10/18/17 at 11:00 a.m. On 10/19/17 at 11:00 a.m., escorted by the Director of Maintenance and the Director of Environmental Services, the following environmental issues were identified: On Unit I, 10 random rooms were inspected and four of the Heating and Air conditioning (HVAC) units were not sealed in rooms, 42, 43, 44 and 58. The gaps around the HVAC system were large enough to visualize the outside. Rooms 52, 54, 56 and 60 had spider webs around the HVAC systems. The hallway Covbases (baseboards) were worn and possessed brown substance along the edges. The Maintenance Director and the Director of Environmental services stated they can no longer be cleaned and need to be replaced because dirt and wax is embedded along the Covbases. Some of the Covbases in the resident's rooms were peeling away from the walls. On Unit II, 10 random rooms were inspected and all 10 window valences exhibited accumulated dust and cobwebs. The Director of Environmental Services stated she expected the environmental staff to use the long handle dust broom to dust	F 465	accomplished for those residents found to have been affected by the deficient practice. Hydration cart was cleaned on 10/17/17 by dietary PTAC□s in rooms with gaps large enough to visualize the outside 42,43,44,58 were temporarily sealed Rooms 52,54,56,60,114,118,110,111 where cleaned of all cobwebs on 10/19/17. Cove base will be replaced in hallways, resident□s rooms, dining rooms. Stained ceiling tiles were replaced 11/2/17. All wallpaper in the facility will be repaired or removed and wall will be painted. All window valances and window blinds were cleaned of dust on 10/19/17. How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. Hydration cart located in the outside courtyard will be cleaned on the 3-11 shift by dietary. The dietary manager will audit the daily cleaning and record the findings on a tracking tool. Daily for 1 week, 2x per	

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F 465	Continued From page 29 the valances. She stated she would take down all the ones in the building that were dirty, wash and replace them. The hallway Covbases (baseboards) were worn and exhibited a brown substance along the edges. Some of the Covbases in the resident's rooms were peeling away from the walls. On Unit III, the hallway Covbases were worn and exhibited a brown substance along the edges. Some of the Covbases in the resident's rooms were peeling away from the walls. On Unit IV, 10 random rooms were inspected and all 10 window valences exhibited accumulated dust and cobwebs. Cardboard boxes were stacked in room 114 and 118. Cobwebs were observed around the the HVAC systems in room 110 and 111. The hallway Covbases were worn and exhibited a brown substance along the edges. Some of the Covbases in the resident's rooms were peeling away from the walls. On Unit V, 10 random rooms were inspected and 4 of the window valances exhibited dust and cobwebs. The hallway Covbases were worn and exhibited a brown substance along the edges. Some of the Covbases in the resident's rooms were peeling away from the walls. The Covbases in the unit dining rooms and main dining rooms were worn with dark substance along the edges. All the resident rooms in the building with door jams at the threshold possessed heavy accumulations of dirt on both sides. The Maintenance and Environmental Director stated they take scrapers and try to clean that portion of	F 465	2 weeks, 1x per month for 1 month. PTAC□s will be audited for gaps on a weekly basis until replacement. Maintenance will record the findings on a tracking sheet weekly until replacement. Education will be provided to housekeepers to ensure window blinds and valances are dust free and cobwebs are removed. Director of Facilities will audit blinds and valances for dust 3x per week the 2x a week for 1 month then 1x a month for 1 month. Maintenance will audit for stained ceiling tiles weekly and replace them as needed. This will be added to the Maintenance round sheets. Cove Base and wallpaper quotes have been submitted and will be replaced. Indicate how the facility plans to monitor its performance to make to ensure that solutions are sustained. Audit results will be reported by the Director of Facilities and the Director of Maintenance in the monthly Quality Assurance and Performance Improvement meeting ongoing for further recommendation and/or suggestions and follow-up as needed. Completion Date: 12/3/17	

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F 465	Continued From page 30	F 465		

the floor upon entry to resident rooms, but because of the dirt and wax buildup, they were unable to clean those areas. The Maintenance Director stated if they were provided the resources, they would replace the Covebases, remove all wall paper, paint hallways and resident rooms.

Stained ceiling tiles were observed in the day room.

Wall paper was observed peeling off most of the walls in the resident hallways.

All door casings were observed with dents and gashes.

On 10/19/17 at 4:15 p.m., the Administrator was made aware of the issues identified during the general observations.

The Environmental rounds check list indicated ceiling tiles and HVAC vents were checked to ensure they were clean and stain free.

The Maintenance rounds preventative check list indicated the conditions of the HVAC units were checked to ensure they were sealed, the Covebases were intact, ceiling tiles were replaced as needed and air vents cleaned.

The facility's policy and procedures titled "Cleaning and Disinfection of Environmental Surfaces" dated 8/2010 indicated walls, blinds and curtains will be cleaned and high and low dusting daily and when visibly dirty or soiled. All floor areas to be cleaned and disinfected in resident living environment.

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F 469	Continued From page 31	F 469		
F 469 SS=F	MAINTAINS EFFECTIVE PEST CONTROL PROGRAM CFR(s): 483.90(i)(4) (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on general observation, group interview and facility documentation review, the facility staff failed to ensure the facility was free of pests (roaches and spiders) on 5 of 5 units. The findings included: On 10/17/17 at 11:45 a.m., a large live roach was identified in resident room #26. The Unit II Charge Nurse recorded the roach sighting in the pest control long. Review of the pest control log for Unit II revealed consistent roach sightings for over four months. On 10/17/17 at 11:30 a.m., two large roaches were identified in the conference room. During the group interview that was conducted on 10/18/17 at 11:00 a.m., five residents that represented the facility on all units, stated roaches and spiders were a common presence in the facility and they were upset that the roach and spider situation was out of control. During general observations of the facility on 10/19/17 the following random rooms were chosen on all five facility units that exhibited Spiders and/or cobwebs: On Unit I, 10 random rooms were inspected and four of the Heating and Air conditioning (HVAC)	F 469	F-469 How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. The facility will implement a change in the Pest Company□s contract to increase service to twice a month in treating all resident□s rooms and common areas for three months. Maintenance will complete audit of facility to look for gaps of penetration (i.e. exit door thresholds, plumbing and PTAC units) then seal to prevent pests from entering facility. Indicate how the facility plans to monitor its performance to make to ensure that solutions are sustained. Monitor Pest logs weekly for observation of pests. Audit results will be reported by the Director of Facilities and the Director	12/3/17

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F 469	Continued From page 32 units were not sealed in rooms, 42, 43, 44 and 58. The gaps around the HVAC system were large enough to visualize the outside. Rooms 52, 54, 56 and 60 had spider webs around the HVAC systems. The Maintenance Director and the Director of Environmental services were present during these observations and stated the gaps around the HVAC systems could be entry points for pest. On Unit II, 10 random rooms were inspected and all 10 window valences exhibited accumulated dust and cobwebs. The Director of Environmental Services stated she expected the environmental staff to use the long handle dust broom to dust the valances. She stated she would take down all the ones in the building that were dirty, wash and replace them. On Unit IV, 10 random rooms were inspected and all 10 window valences exhibited accumulated dust and cobwebs. Cardboard boxes were stacked in room 114 and 118. Cobwebs were observed around the the HVAC systems in room 110 and 111. The Director of Environmental Services stated she would obtain some large totes to replace the cardboard boxes that may harbor pests. On Unit V, 10 random rooms were inspected and 4 of the window valances exhibited dust and cobwebs. The Director of Environmental Services stated she would take all the valences down, make sure the windows were free of webs and any spiders and replace the the valences. On all five units, roaches and spiders were entered into the pest control sightings log book over past four months.	F 469	of Maintenance in the monthly Quality Assurance and Performance Improvement meeting ongoing for further recommendation and/or suggestions and follow-up as needed. Completion Date: 12/3/17	

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F 469	Continued From page 33 On 10/19/17 at 4:15 p.m., the Administrator was made aware of the issues identified during the general observations. The Administrator stated the pest control company came to the facility twice and month and performed routine treatments, checked all unit pest log sighting books and addressed any other areas to be treated. The Environmental rounds check list indicated the HVAC units were checked. No record of gaps identified around the units. The Maintenance rounds preventative check list indicated the conditions of the HVAC units were checked to ensure they were sealed. The Environmental rounds weekly check list did not identify the cobwebs and spiders on the valences or around the HVAC units. The pest control company contract dated 2/10/15 indicated they treated the entire building for spiders and roaches to include resident rooms.	F 469		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		12/3/17

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F 514	Continued From page 34 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and clinical record review the facility staff failed to ensure the Physician Order Sheet, the Treatment Administration Record and Comprehensive Person-Centered Care Plan were accurate for 1 of 27 resident's in the survey sample, Resident #1. The findings included: Resident #1 was admitted to the facility on 2/28/11 with a readmission date of 9/12/14 with diagnoses to include, but not limited to: dementia	F 514	F-514 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident #1 TAR order for a Bed/Chair alarm was discontinued on 10-18-17. 2. An order was written to Pharmacy as a second request to discontinue the Bed/Chair alarm on 10-18-17.	

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F 514	Continued From page 35 with behavioral disturbances, osteoporosis (softening of bone-seen most often in elderly) and history of a stroke and falls. The current MDS (Minimum Data Set) with a assessment reference date of 7/11/17 assessed the resident as having long and short term memory deficits with severely impaired daily decision making skills. The resident required extensive assistance of two for bed mobility and transfers. The Comprehensive Person-Centered Care Plan initiated on 10/28/16 and dated as recently reviewed on 10/13/17, identified the resident had potential for falls due to a history of falls, diagnoses of osteoporosis, impaired and poor safety awareness, as evidenced from psychotropic meds, resident has a history of sitting self on the floor. The goal was that the risk for falls will be managed through nursing interventions over the next 90 days. One of the interventions listed to achieve and maintain the goal was for the implementation of bed and chair alarms. On 10/17/17 at 2:45 p.m. and 4:00 p.m., Resident #1 was observed sitting up in a wheelchair in the resident's room. There was no chair alarm. On 10/18/17 at 9:45 a.m., 1:00 p.m., and 3:00 p.m., the resident was observed in bed. There was no bed alarm. The Physician Order dated 5/18/17 read: "D/C (discontinue) chair and bed alarm, continue on Q (every) 2 hrs rounds". The current Physician Order Sheet included	F 514	How the facility will identify other residents having the potential to be affected by the same deficient practice. All resident have the potential to be affected. A 100% audit of resident orders sent from the Beacon Shores to PharMerica pharmacy will be checked for accuracy and notification of audit results sent to the Director of Nursing by 11-10-17. (3) What measures will be put in place or systemic change made to ensure that the deficient practice will not recur. 1. Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator or Unit Manager will place a monthly sheet for Licensed nurses to check orders daily on the 11-7 shift in every resident medical record, and follow-through from order to MAR, TAR and Lab book requiring Licensed 11-7 nurse signature. 2. Unit Managers will check yellow orders sheets and monthly order sheet for accuracy daily in the morning meeting and document in the care plan section of the resident medical record, and record order in the acuity log. 3. All licensed nurses will be in-serviced on facility policy and procedure for checking orders and turning over of Physicians Order Sheet (POS), MAR□s, and TAR□s monthly as well as the new daily checking of orders monitoring tool by 11-10-17 (4) How the facility will monitor its corrective actions to ensure the deficient	

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	495150	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 36 under Safety Orders- Bed and chair alarm-check placement and function twice a day every shift. The Treatment Administration Record (TAR) for October 2017 had an entry that read: Bed and chair alarm-check placement and function twice day every shift. The entry was initialed off daily from October 1st through October 18th by the nursing staff on all three shifts as being completed. On 10/18/17 at 3:30 p.m., the day shift nurse assigned to care for Resident #1 was interviewed (Licensed Practical Nurse #1). The nurse had initialed on the TAR for today that the bed/chair alarm was in place and the function was checked. She was asked what safety interventions were in place for the resident. She stated, "low bed, fall mats on both sides, self release belt...". When asked about bed/chair alarm, she stated, "I can't remember, I think she does...". Upon entering the room, the resident was in bed asleep. There was no bed alarm. On 10/18/17 at 3:45 p.m., the unit manager was interviewed. The above observations and the inaccurate Physician Order Sheet, the TAR and the Comprehensive Person-Centered Care Plan were shared. She stated the bed and chair alarm order was discontinued and the nursing staff had failed to take the entry off the TAR. She stated she was responsible for removing the entry off the care plan, stating "I should have caught it". The above findings of the inaccurate Physician Order Sheet, the TAR and the Person-Centered Care Plan for Resident #1 was shared during the pre-exit meeting conducted on 10/19/17 at 3:35 p.m., with the CEO, the Director of Nursing	F 514	practice is being corrected and will not recur. 1. The Director of Nursing will present findings of the new daily order monitoring tool and compliance to the monthly Quality Assurance Performance Improvement Committee for further recommendations and/or follow up as needed (5) Completion Date: 12/3/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 10/19/2017

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BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

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F 514	Continued From page 37 (DON) and Corporate nurse in attendance. The DON stated she had identified that there were errors with the pharmacy not taking off discontinued orders from the TAR's when faxed.	F 514		